AAHomecare Comments to House Republican Healthy Task Force
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1. Introduction

The American Association for Homecare (AAHomecare) is the national association representing durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers, manufacturers, and other stakeholders in the homecare/home medical equipment (HME) community. Our members manufacture, distribute and provide medically necessary DMEPOS items and services to patients in their homes.

The Social Security Act's definition of durable medical equipment (DME) was drafted in 1965. In the 57 years since then, home medical device and supply technology has changed dramatically. For example, the definition references iron lungs and oxygen tents, which are equipment that have not been provided in decades. The current statutory definition needs to be updated to facilitate beneficiary access to current technology. The COVID-19 public health emergency (PHE) has shone a spotlight on the availability and significant economic, health and social benefits of home-based care. In fact, patients can now receive hospital-level care at home, where acute patients receive the same level of medical care in their homes as they would in a hospital setting – at significantly less cost.

2. Congress should update the Social Security Act's definition of DME

AAHomecare recommends that Congress modify the definition of DME "durable medical equipment" (SSA §1861(n)) to reflect 2022 technology. For example, the statutory definition includes the term "iron lungs," a technology that has been obsolete for many decades. In addition, the law's DME definition should include disposable, medical supplies, wearable technology, remote monitoring devices and other items that are 21st century technology that beneficiaries use in the homes, but do not fit into the confines of an antiquated DMEPOS definition.

-AAHomecare supports H.R. 2356, which would modify the Medicare payment methodology for disposable negative pressure wound therapy devices. The bill specifies that payment must be a national payment rate for the device itself and not for related professional services or visits and must be made as an add-on payment for the device under the prospective payment system for home health services.

- Congress should remove the "in-the-home" verbiage to ensure beneficiaries can utilize home-based technologies outside their homes. CMS has interpreted the phrase "in the home," within the definition of "durable medical equipment" beyond the original

intent of Congress. Section 1816(n) of the SSA states: The term "durable medical equipment" includes iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home…" This definition makes sense as the equipment must be required to meet the beneficiary's needs within their home; however, most who qualify for Medicare, Medicaid or any other insurance program are not sequestered full-time within the four walls of their home. A person's "home" and normal activities of daily living expand to the world beyond their home. This includes every day needs such as medical visits and grocery shopping. If anything, the current COVID-19 pandemic has shown that the population that is not disabled does not want to be required to stay within their home. How could anyone expect this to be normal in the everyday life of a disabled person or anyone who qualifies for Medicare or Medicaid, even after the pandemic ends.

CMS has interpreted this "in the home" language to mean that certain items (e.g., mobility assistive equipment) must be necessary to perform certain activities of daily living (e.g., bathing, toileting, feeding/eating & dressing) within the home. CMS has used this language to justify restrictive coverage guidelines for mobility devices (canes, crutches, walkers, other ambulatory aids, wheelchairs, scooters and power wheelchairs). CMS' interpretation results in access issues for people with disabilities. Beneficiaries therefore have limited access to rehab and assistive technology that can enable them to independently move about the communities in which they live.

3. <u>Congress Should Address the Deficiencies of the HCPCS coding system</u>

The current HCPCS code set for DMEPOS items is inadequate. There appears to be a CMS institutional unwillingness to expand the HCPCS code set. This has resulted in a myriad of problems including:

a. Under-defined HCPCS codes that contain too broad a range of products with a subjective code verification process;
b. Products that receive payment rates that are too low, or too high;
c. A disincentive for medical device/supply manufacturers to innovate;
d. A lack of new/appropriate HCPCS codes for innovative technologies and enhancements; and
e. The inability to use an Advance Beneficiary Notice (ABN) to allow a beneficiary to upgrade products within the same HCPCS code. This prevents beneficiaries from applying their Medicare benefit towards a DMEPOS item that provides them more value.

Many of the DMEPOS HCPCS codes do not represent a homogenous group of products but rather include a broad range of items from simple items to high-end complex items. For example, HCPCS code E0955, a wheelchair headrest HCPCS code includes everything from very basic to very complex head support systems. HCPCS code E0978, a positioning belt/safety belt/pelvic strap code, includes everything from very basic seat belts to complex pelvic support systems. The problem with grouping a wide range of technology under one code is that it fails to adequately recognize and reflect unique features, application and benefits. Further, since the payment rate is established at the HCPCS code level, it

inadequately compensates for more complex/costly items while potentially overcompensating simple/inexpensive items assigned to the same code.

For decades, CMS has exhibited a strong aversion to expanding the HCPCS code set. Congress should establish a more reasoned policy that allows for more HCPCS codes, along with more specifications within the codes. For example, HCPCS codes should incorporate details such as materials, durability, features and/or applications. There are many DME items that do not have a proper HCPCS code. For example, Medicare has established HCPCS codes for oversized/bariatric hospital beds; but no HCPCS codes exist for bariatric sizes of full support surfaces that would be placed on such beds. CMS recently published an article reinforcing its unwillingness to recognize bariatric-sized support surfaces, even though the design, materials, and costs associated with bariatric-sized support surfaces would increase, just as it does for bed frames.

CMS' HCPCS coding system encourage product offerings based on lowest cost rather than what may be the most medically appropriate for the individual. As a result, Medicare beneficiaries may be less likely to receive advanced materials and technology with higher quality and better durability. The broad grouping of products within a single HCPCS code places the premium products at a competitive disadvantage because there is a financial incentive to provide the less expensive items within the same HCPCS code.

In addition, CMS has restrictively implemented the Advance Beneficiary Notice (ABN) process to disallow beneficiary access to higher end items within the same HCPCS code, exacerbating beneficiary access to the most medically appropriate items.

CMS should expand HCPCS coding to ensure that each code represents a distinct, homogenous group of products and stop co-mingling disparate items.

The current HCPCS code system provides little incentive for manufacturers to innovate. The lack of specifications within HCPCS codes and CMS' unwillingness to routinely enhance coding and code descriptors discourages manufacturers from developing product improvements and new products that could benefit the consumer clinically and/or functionally. Typically, HCPCS codes include minimum product specifications that a product must meet in order to use the associated code for billing. However, in many cases these specifications are very minimal and only reflect the materials and technology that existed at the point the code was created.

4. **<u>Congress should expand coverage for remote patient monitoring.</u>**

AAHomecare recommends that Congress expand coverage and payment for remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services to further enable access and quality of care for beneficiaries. In previous years, the Centers for Medicare and Medicaid Services (CMS have recognized and reimbursed these remote monitoring codes. AAHomecare appreciates the agency's willingness to adopt solutions that provide beneficiaries with innovative digital products that will enhance health care delivery, and make effective and coordinate care in the home a critical reality for the aging

population. Digitally enabled medical devices, including certain DME items, help collapse time and space by capturing snapshots of physiologic data. The exciting area of digital health allows multifaceted capture, documentation, and reporting of precise health conditions, triggering events, dates, times, and other contextual data. Some devices not only monitor the patient's disease status but also deliver medicine or therapeutic care. Using digitally enabled medical devices and their associated services, medical practitioners and payors can monitor patient conditions, while documenting use, functions, trends, conditions, environmental status, location, and other aspects of patient compliance, care, and necessities. Physicians and other health care professionals can utilize home use medical devices to gather information associated with diagnosing, treating, or managing a clinical condition. Unlike before when this information was only captured episodically in between medical visits, the availability of this new information can help improve care management, leading to better patient outcomes, and potentially resulting in increased cost savings.

For the purposes of gathering information related to diagnosing, treating, and managing a clinical condition for which DMEPOS is ordered, AAHomecare recommends that CMS allow remote monitoring to be used to satisfy ongoing face-to-face encounter requirements. Remote monitoring services enable physicians and other qualified health care professionals to gather information and monitor patient treatment. Medical devices that are digitally enabled should be allowed to be used to satisfy the requirements for the face-to-face encounter.

AAHomecare recommends that CMS adopt policies that would improve the partnership between the DMEPOS industry and the physician community in caring for patients. DMEPOS suppliers are more frequently in contact with beneficiaries after a doctor's visit and are in the position to monitor and communicate patient issues to physicians and the caregiving team. In addition, some DMEPOS suppliers already provide equipment that has monitoring technology which has improved the ability of health care professionals to supervise patient health care in real time. RPM can be used in tandem with expanded virtual services to provide a robust patient-centered visit without the need for an in-person visit. There are already many DMEPOS suppliers that provide RPM technology, but currently suppliers are providing this service without any reimbursement. Paying DMEPOS suppliers for their respective roles in providing this service would be more economical than an in-person physician visit and should be considered as part of a comprehensive telehealth expansion.

An important piece of this consideration is expanding the list of Medicare eligible non-physician providers who may provide telehealth and evaluation and management services through digital health. The types of healthcare professionals that can furnish distant site telehealth services has currently been expanded through 1135 waivers. This includes all providers that are eligible to bill Medicare for their professional services. The expanded list of healthcare providers now includes physical therapists, occupational therapists, and speech language pathologists. AAHomecare recommends Congress update the statute[1] to permanently revise or otherwise expand the list of practitioners permitted to received

[1] 42 USC § 1395m(m)(1) permits the Secretary to pay for telehealth services that are furnished by a "physician" or a "practitioner," as those terms are defined in 42 USC § 1395x(r) and 42 USC § 1395u(b)(18)(C), respectively

Medicare reimbursement for telehealth services. Additionally, Congressional action would be necessary to permanently expand the list of practitioners permitted to receive Medicare reimbursement for evaluation and management (E/M) services that may be accomplished through digital health (i.e., care management services, communication technology-based services, virtual care, eVisit, etc.).

Additionally, as Medicare and Congress increase the focus on providing better care, maximizing patient outcomes, and creating efficiencies, it is clear that digital connected health technologies will play a pivotal role in this evolution of health care. Leveraging these technologies and providing reimbursement incentives will encourage adoption and collaboration between healthcare providers, patients and caregivers, and also offer significant opportunities to reduce costs. For example, in respiratory care, digital health technologies and cloud-connected medical devices transform care for people with sleep apnea, COPD, and other chronic diseases. Today, many continuous positive airway pressure (CPAP) devices, bilevel respiratory devices, and home mechanical ventilators are cloud-connected, enabling physicians and respiratory specialists to remotely monitor their patients. When used together, a patient facing therapy engagement application and secure cloud-based provider facing software system have been shown to increase 90-day, CMS-defined therapy adherence to 87% compared to 70% of patients being monitored in a provider facing system alone.[2] There could not be a clearer case for the use of digital health and remote monitoring than the current COVID-19 public health emergency (PHE).

A number of European countries have led the charge in recognizing the value of connected health solutions and validating the importance of remote monitoring technology, including incremental increases in reimbursement for the use of connected devices for patients who are remotely monitored and adherent to therapy. Medicare has taken an important step in enabling the adoption of these technologies through the creation of the RPM/RTM physician codes. However, new payment models to incorporate and drive further adoption of these technologies is desperately needed.

The healthcare ecosystem, including HME suppliers, recognize a significant opportunity to provide effective care to patients while improving business efficiencies and lowering costs through a differential reimbursement for a DME product that is connected and enables greater care coordination.

5. Value-Based Care

Better coordinated care for patients with chronic conditions, including the supply of DME and digital technologies, can improve care and health outcomes. DME is a reimbursement category, but different types of DME are in fact quite different in the conditions they treat and their importance in enabling and driving care coordination. Some treat conditions that are relatively stable over time; some treat chronic diseases that worsen over time and drive increased healthcare utilization (and costs) as disease progresses.

[2] Malhotra A et al. Chest 2018

6. **<u>Congress should expand telehealth coverage, consistent with what have been available during the COVID-19 PHE.</u>**

AAHomecare strongly support the expansion of telehealth services to facilitate access to care while minimizing in-person encounters, especially during this COVID-19 pandemic. Telehealth is an efficient way for practitioners and beneficiaries to communicate and can often effectively replace in-person visits, with no concomitant disadvantages. We recommend that certain virtual services that are allowed during the PHE also be allowed on a permanent basis after the PHE. We recommend, however, that virtual services be reserved for physicians and other prescribers with an established beneficiary relationship. Clinicians should be responsible to decide whether a visit with their patient should be in-person or virtual.

Virtual visits are especially beneficial for on-going monitoring of patients because HME suppliers are generally more frequently in contact with their patients than clinicians. This is because most equipment provided by HME suppliers are rental equipment, such as wheelchairs and oxygen concentrators, or monthly supplied services such as enteral nutrition, or disposable medical supplies. Expanding telehealth services during this PHE has enabled HME suppliers to have more regular check-ins with patients and monitoring equipment usage.

One of the benefits of telehealth is it provides an opportunity for patients to seek medical care before needing to visit a facility. There have been multiple news articles on how the pandemic is likely keeping patients away from hospitals and emergency departments. The expansion of telehealth during this PHE is likely limiting some types of emergency visits. Telehealth expands access to care by allowing patients to obtain medical attention without leaving their homes. This is especially important for high-risk patients who should limit leaving their homes during this pandemic.

Prior to the PHE, telehealth was limited to Medicare beneficiaries residing in rural areas. Although the availability of telehealth has been very helpful for rural communities, the difficulty accessing a clinician's office is not limited to rural areas. For a variety of reasons, even beneficiaries residing in urban areas can struggle to visit a doctor's office. Whether it be due to a transportation issue, due to the patient's medical condition (such as limited mobility), or due to the flu season/pandemic (where the patient is fragile), there are situations when telehealth is safer than an in-person visit. The geographic barrier to virtual visits should be removed. The HME industry has received positive feedback from patients on the expanded use of telehealth. Expansion of telehealth has greatly improved the access to care without compromising the quality of services. Congress should remove the geographic restrictions and expand eligible services. The COVID-19 pandemic has demonstrated that telehealth is an effective alternative to in-person visits.

AAHomecare strongly supports interoperability between payors and providers. Ensuring interoperable telehealth access improves administrative efficiency and patient care AAHomecare recommends that Congress enact policies that encourage partnerships between HME suppliers and physicians in caring for patients. HME suppliers are more

frequently in contact with beneficiaries after a doctor's visit and are in a good position to monitor and communicate between patients, physicians, and referral sources. In addition, some HME suppliers already provide equipment that has monitoring technology which has improved monitoring patient health in real time. RPM can be used in tandem with expanded virtual visits to provide a robust patient-centered visit without the need for an in-person visit. There are already many HME suppliers that provide RPM technology, but currently suppliers are providing this service without any reimbursement. Paying for this service would be more economical than an in-person physician visit and should be considered as part of a comprehensive telehealth expansion.

The HME industry is part of the solution in keeping patients safe at home. Due to the nature of services HME suppliers provide, patient monitoring is an integral part of a supplier's services. Being able to use telehealth for more services during this pandemic has improved the supplier community's ability to regularly check-in with patients. For certain equipment, CMS requires that beneficiaries bring their equipment with them for an in-person visit. The purpose of these visits is to have the clinician check-in with the patient to ensure they are using the equipment properly and to determine if the equipment is still medically needed. This type of visit can be effectively conducted via a virtual visit. Allowing for this check-in to be virtual would improve access and convenience for patients. AAHomecare recommends that whenever a face-to-face encounter is required, telehealth should be accepted. The use of telehealth, however, should be at the discretion of the physician.

Although there is a lot of material focused on educating the provider community on utilizing virtual visits, we have not seen educational materials available for beneficiaries. AAHomecare recommends that CMS and other payors educate patients on effectively using virtual services.

Lastly, we recommend that policies on telehealth/virtual visits should keep pace with available technology. The current telehealth regulations are already outdated and there is a need for policies to be updated on at least an annual basis, to incorporate new technology that is available in the market.